

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-010452

DEPARTMENT OF PUBLIC HEALTH AND WELFARE 042

1000

335

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED MAR 18 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
Length of stay in 1b 17 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Meth. Hosp. & Med. Center		d. STREET ADDRESS (If outside, give location) 3401 Monterey	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLYDE Middle CLAYTON Last BRADY		4. DATE OF DEATH Month March Day 9, Year 1963	
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/22/1889
9. AGE (last birthday) 73		10. IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired civil service		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (City and state or country) Fly, Ohio		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Jhon T. Brady		13b. MOTHER'S MAIDEN NAME Mary Haight	
14. NAME OF HUSBAND OR WIFE Jennie Mae		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT C.W. Brady, 2425 E. 54th, Tulsa, Okla.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY... IMMEDIATE CAUSE (a) Cerebrovascular thrombosis DUE TO (b) Hypertensive & arteriosclerotic DUE TO (c) cardiovascular disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) carcinoma of prostate		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 3/7/63 to 3/9/63 and last saw him alive on 3/9/63 Death occurred at 11:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Donald Stallard, MD (Degree or title)	
22b. ADDRESS 902 E. 2nd		22c. DATE SIGNED 3/12/63 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 3/13/1963	
23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION (City, town, or county) St. Joseph Mo.	
24. FUNERAL DIRECTOR Heston-Brown		25. DATE RECD. BY LOCAL REG. Mar. 14, 1963	
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

D. Stallard, Medical Certification

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/59

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MAR 19 1963

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Removal record 3-12-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer:

Signed Eugene Wood

Licensed Embalmer No. 3804
P. O. Address 319 So 10th, St. Joseph, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.